PCMA

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

Statement for the Record of the Pharmaceutical Care Management Association Submitted to the

UNITED STATES HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON OVERSIGHT

"Hearing on Improving Efforts to Combat Health Care Fraud"

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The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). PCMA appreciates the opportunity to submit a statement for the record to the Subcommittee on Oversight of the Committee on Ways and Means related to health care fraud, waste and abuse (FWA).

PBMs typically reduce drug benefit costs by 30 percent for public and private payers by encouraging the use of generic drug alternatives, negotiating discounts from manufacturers and drug stores, saving money with home delivery, and using health information technology like e-prescribing to reduce waste and improve patient safety. Prior to the advent of these tools, there was no system wide approach to fully address the real dangers and costs of misuse, overuse, or under-use of prescription drugs. In the Medicare Part D program, research cited by the Centers for Medicare & Medicaid Services (CMS) notes that strong Part D plan negotiations have been a key driver in the benefit, which is now expected to cost taxpayers $373 billion over ten years, a 41 percent drop from the initial cost estimate of $634 billion for 2004-2013.

Most estimates of Medicare fraud are at three to ten percent of all claims. With increasing spending along with the complexity of our health care system, the amount of total dollars lost due to fraud will only increase, barring systematic and successful detection and prevention. Although not a significant area for fraudulent activity, prescription drugs are not immune to this threat. Whether it is through doctor and pharmacy shopping to obtain prescription drugs illegally, or simply a pharmacy billing for more prescriptions than it actually dispenses—law enforcement, Part D plans, and pharmacy benefit managers (PBMs) must remain vigilant.

PBMs are dedicated to providing access to affordable prescription drugs while protecting tax payer resources from FWA. Pharmacy claims, unlike medical claims, are typically adjudicated in real-time as the patient stands at the pharmacy counter or upon dispensing the drug by a mail-service pharmacy. Most of these claims are adjudicated electronically, which not only provides a seamless process for the beneficiaries, but also provides the ability to stop the more obvious FWA from occurring. In addition, PBMs monitor overall claims and detect patterns of potential abuse or fraud. For example, an individual who fills multiple prescriptions at multiple pharmacies is a likely fraud candidate, as is a pharmacy whose claims sharply increase in a given period of time.

With nearly 5 billion prescription drug claims processed per year, detecting and preventing FWA before a claim is paid is far superior to paying a claim and then chasing down the fraudster to pay it back, known as "pay and chase." Unfortunately, one statutory provision in Part D makes it especially difficult for Part D plans to avoid "pay and chase" scenarios: a requirement that a Part D plan pay a pharmacy within fourteen days regardless of suspicion of fraud. Even if a PBM has evidence that a fraud is occurring, as long as the claims that have been submitted are "clean," it must pay them. This is not the case in any other part of Medicare.

As with any business, PBMs rely on auditing their contracted pharmacies periodically to ensure that they are not engaged in less detectable forms of fraud—small dollar transactions or others that may seem legitimate until studied more closely. In a business that transacts nearly 5 billion claims annually, there must be unfettered ability to audit randomly and with little notice, to provide greater opportunity to detect pharmacy fraud.

PCMA believes that the National Health Care Anti-Fraud Association's (NHCAA) analysis entitled "Seven Guiding Principles for Policymakers" in fighting health care fraud underscores the efforts PBMs are making to detect and prevent fraud. At the same time, the NHCAA's analysis raises questions about legislative efforts in the 111th, and potentially 112th, Congress to reduce accountability and oversight especially of independent pharmacies.

Some policy proposals meant to help independent pharmacies inadvertently open the door to fraud, abuse, and wasteful spending. The NHCAA's white paper suggests that the following types of policies, many of them contained in recent legislative proposals, would be problematic:

Policies that require payers to partner with pharmacies that are banned from federal programs ("Any Willing Pharmacy" policies). Legislation that would force plans to include in their networks even pharmacies that have been banned from federal programs "runs counter" to preventing fraud, according to NHCAA. This low bar would allow admission for pharmacists "even if they have records of harmful prescription errors or a high number of consumer complaints."

Policies that undermine payers' ability to audit independent pharmacies suspected of fraud ("Audit Reform" policies). CMS is required by law to audit Medicare Part D plans every three years. Similarly, many pharmacy benefit managers periodically audit pharmacies that are part of their networks. In addition to random audits, PBMs typically request audits upon suspicion of fraud. NHCAA supports measures that would "protect the integrity of health care audits by giving auditors more discretion and flexibility to perform their duties." Unfortunately, legislative proposals championed by the independent drugstore lobby would instead grant pharmacies (even those with wasteful or abusive practices) substantial advance notice before they were subject to audits. PCMA supports continuing to permit PBMs and health plans to audit as needed both randomly and upon suspicion of fraud, without notice.

Policies that reduce payers' time to verify pharmacy claims before payment ("Prompt Pay" policies). PCMA believes strongly that insufficient time to investigate potential fraud before paying a claim leads to so-called "pay and chase." It is much more difficult to recover payments after the fact than to spend adequate time identifying potentially fraudulent claims and avoiding paying them. In its report, NHCAA notes that "if claims are not rushed through the payment process, auditors and investigators will have more opportunities to detect attempts at fraud before they come to fruition." So-called "prompt pay" laws in Medicare Part D that mandate rapid payment reduce the time available to detect pharmacy fraud, waste, and abuse and should be repealed. At the very least, Part D plans should be able to suspend payments when they suspect fraud, reflecting the same authority already provided in Medicare Parts A and B. What is good for one part of the program should be good for the other part.

On behalf of PCMA and our members, we look forward to working with the Committee to develop ways in which to rid the system of fraud, waste and abuse to safeguard federal government resources, while ensuring that patients maintain high access to needed medications.